State of Tennessee
Department of Children's Services

INITIAL HEALTH QUESTIONNAIRE

DATE _____

NAME _____ **DOB** _____ **SSN** _____

INFORMATION PROVIDED BY _____ **RELATIONSHIP** _____

*** If no information available, please explain _____

SCHEDULED APPOINTMENTS (Please list any scheduled appointments for the child giving date, provider, type of appointment)

_____

CURRENT MEDICATIONS (Please list all prescription and over-the-counter medications child is currently taking)

_____

ALLERGIES
Does the child have any allergies (medication, food, insect stings, etc)? ☐ Yes ☐ No
If yes, please specify allergy and reaction _____

HEALTH HISTORY OF CHILD (Please explain any checked item in "COMMENTS" section on next page)

☐ Abuse (physical or sexual)
☐ ADHD
☐ Alcohol or Drug Use
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bipolar Disorder
☐ Birth Defects
☐ Blood Clots
☐ Cancer
☐ Depression/Anxiety
☐ Developmental Delays
☐ Diabetes
☐ Epilepsy/Seizures
☐ Gastrointestinal Problems
☐ Hearing Impairment
☐ Heart Murmur
☐ Heart Disease/Problems
☐ High Blood Pressure
☐ Kidney/Urinary Problems
☐ Migraine Headaches
☐ Psychosis
☐ Rheumatic Fever
☐ Sickle Cell Disease
☐ Suicidal Thoughts/Attempts
☐ Skin problems
☐ Tobacco Use
☐ Tuberculosis (TB)
☐ Vision Impairment/Problems
☐ Other Problem _____

CHILDHOOD ILLNESSES (Please include approximate dates)

☐ German Measles _____
☐ Measles _____
☐ Mumps _____
☐ Chicken Pox _____
☐ Scarlet Fever _____
☐ Rheumatic Fever _____

Is child sexually active? ☐ Yes ☐ No Any history of STD? ☐ Yes ☐ No If yes, date/treatment _____
Does child use birth control? ☐ Yes ☐ No Method? _____

GIRLS ONLY
Age of menarche _____ Date of last period _____ Frequency of periods _____ Length of periods _____

MEDICAL
Does the child have a regular medical provider (pediatrician, family doctor, etc)? ☐ Yes ☐ No
If yes, please list name of provider _____ Date of last visit? _____

IMMUNIZATIONS
Are immunizations up to date? ☐ Yes ☐ No Is copy of immunization record available? ☐ Yes ☐ No
Where were immunizations received? _____

DENTAL
Does the child have a regular dental provider? ☐ Yes ☐ No
If yes, please list name of dentist _____ Date of last dental exam? _____

VISION
Does the child wear corrective lenses? ☐ No ☐ Glasses ☐ Contacts
Date of last vision exam? _____ Name of Vision Provider? _____

MENTAL HEALTH
Has the child ever been treated or hospitalized for a mental illness or suicide attempt? ☐ Yes ☐ No
If yes, please list date and hospital _____
Has the child had a psychological evaluation? ☐ Yes ☐ No
If yes, please list date and provider _____

BIRTH HISTORY (for children under 6 years of age)
How many times has child's mother been pregnant? ____ Number of living children ____ Number of miscarriages/abortions _____
Did mother receive prenatal care with this child? ☐ Yes ☐ No If yes, what month of pregnancy did prenatal care begin? _____
How many prenatal visits did mother attend? _____ Was there any prenatal substance abuse? ☐ Yes ☐ No
Pregnancy Complications? _____
Birth Weight _____ Birth Length _____ ☐ Vaginal Birth ☐ C-Section ☐ Premature Birth (< 36 weeks) _____ Weeks
Mother's Age at Delivery? _____ Delivery/Birth Complications? _____
Name of Hospital _____ Length of Hospital Stay _____
Was newborn metabolic screening normal? ☐ Yes ☐ No Was newborn hearing screening normal? ☐ Yes ☐ No
If no, please explain _____

FAMILY HEALTH HISTORY (Please check appropriate box of family member for all that apply)

	Father	Mother	Father's Parents	Mother's Parents	Siblings
ADHD	☐	☐	☐	☐	☐
Alcohol or Drug Use	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Depression/Anxiety	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Heart Disease/Heart Attack	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Psychosis	☐	☐	☐	☐	☐
Sickle Cell Disease/Trait	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Suicidal Thoughts/Attempts	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Tuberculosis (TB)	☐	☐	☐	☐	☐
Other Medical Conditions	☐	☐	☐	☐	☐

Are both parents living? ☐ Yes ☐ No
If no, please list parent(s), age at death, and cause of death _____

COMMENTS (Please list any additional health information for the child or family)

_____

_____

_____